CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295067	A. BUILDING _____ B. WING _____	C 12/12/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN AT CC HEALTH & REHAB	3050 N ORMSBY CARSON CITY, NV 89703

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as the result of a complaint investigation initially conducted at your facility on 12/8/06 and finalized on 12/12/06. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil actions or other claims for relief that may be available to any party under applicable federal, state or local laws. Complaint #NV00013645 was a self reported incident in which a resident was injured during a transfer. The injury substantiated and a deficiency was cited at F 272.	F 000	DISCLAIMER CLAUSE PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW.	
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status;	F 272	**F272** Comprehensive Assessments It is the policy of this facility to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. Resident #1 was not harmed by the alleged failure to follow this policy. All residents have the capacity to be affected by this policy. **Alleged deficiency:** Resident #1 was being assisted to a shower by two C.N.A.'s when the resident's leg collapsed under her. The C.N.A.'s assisted the resident to the floor and immediately summoned Nurse #1 to perform an assessment of the resident's possible injury.	12/27/06

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 1/8/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	Continued From page 1 Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility's investigation, and staff and resident interviews, it was determined that the facility failed to adequately assess a resident following an assisted fall with complaints of right leg pain. (Resident #1) Findings include: Resident #1: The resident was admitted to the facility on 9/15/05 with diagnoses that included multiple sclerosis, urinary retention and a decubitus ulcer. The resident's Minimum Data Set (MDS), dated 10/9/06, indicated she had long and short term memory impairment. The MDS indicated that she demonstrated the cognitive skills for modified independent decision-making. On 12/8/06, the resident's records were reviewed. The nurse's notes indicated that on 12/6/06 at approximately 10:00 AM, two Certified Nursing Assistants (CNA's) were transferring Resident #1 out of bed to the shower chair when the resident's legs "folded underneath her" and a cracking sound was heard. The record indicated the resident was "screaming" that her legs hurt.	F 272	Resident #1 care plan indicated that the resident requires a 2-person transfer (which occurred during the transfer at the time of the alleged incident). Nurse #1 allegedly failed to perform a comprehensive assessment of the resident's needs at the time of the incident. **Corrective Action:** Registered Nurse #1 was in serviced on 12/27/06 on proper fall assessment, event reporting, and proper protocol related to resident falls. The Nurse was also in serviced on the facility's policy to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. This in service will also include procedures and protocol for pain assessment utilizing the pain scale, proper notification of incident occurrence (including physician, Director of Nursing, and responsible party if appropriate). All licensed nurses were inserviced on 12/22/06 on proper comprehensive assessments, including fall assessments, event reporting, and proper protocol related to resident falls.	

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F 272	Continued From page 2 Registered Nurse #1 was notified of the incident and assisted the two CNA's in placing the resident into the shower chair. The resident was then showered. The nurse's notes indicated that Resident #1 continued to complain of pain following the shower and was examined by Registered Nurse #1 after she was back in bed. The nurse's notes indicated the right middle hip was swollen and warmer than the right hip. A superficial abrasion was found on the left knee. The resident's physician was notified of the incident and ordered an x-ray of the right knee and hip to rule out fracture(s). The x-ray revealed a fracture of the right femur. On 12/8/06 at 1:30 PM, the Director of Nurses was interviewed. She reported that Resident #1 did not exhibit signs of a leg fracture when first examined by Registered Nurse #1. She denied that the leg was externally rotated or any leg length discrepancy was noted. She reported that the swelling of the leg was observed several hours later. She stated that she did not know of the resident's complaints of right leg pain. The DON stated she was not notified of the incident until 12:45 PM on 12/6/06, after the resident was moved to the shower chair, showered and reexamined by Registered Nurse #1. She stated she would not have moved the resident if there was a popping or cracking sound followed by complaints of leg pain. On 12/8/06, at approximately 2:30 PM, CNA #1 was interviewed. She reported that Resident #1 was normally transferred from bed to wheelchair with the assist of two people. She stated CNA #2	F 272	**Systematic Compliance:** All newly admitted residents will be reviewed by the interdisciplinary team in a timely manner and a plan of care will be developed to ensure the care plan is individualized and meets the standards of the regulations. Director of Nurses will periodically conduct random nursing in-services on assessments, also placing event reporting resources (which includes protocol regarding proper assessment procedures) on each nurses' stations. All resident medical records and individual care plans will be reviewed within the next quarter by the interdisciplinary team to ensure care plans are comprehensive, accurate, and standardized for each resident. Resident fall data collection is to be collected Q-shift by the licensed staff, and documented per policy. **Monitoring:** The Director of Nursing or designee will conduct random audits a minimum of three times per week to ensure compliance and report the findings to the morning management meetings. The facility conducts weekly behavior meetings to review data collected by the	

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F 272	Continued From page 3 requested her help in transferring the resident for a shower. She stated that the resident's legs folded underneath her and the two CNA's gently lowered her to the floor. She reported that a popping sound was heard while the resident was being lowered. She stated that she thought the sound might have been caused by stepping on the resident's catheter and was afraid that urine would spill onto the floor. She reported that the resident said "ouch, ouch, ouch" while sitting on the floor and that she was afraid the resident had been hurt. She denied that the resident ever screamed during the incident. She stated that the resident often complained of discomfort and she thought the resident said "ouch" because she was just nervous about being on the floor and disliked showers. On 12/8/06, the facility's Investigators/Statement of Event form, dated 12/6/06, was reviewed. The form was signed by CNA #1 and indicated the resident had told her that her right leg hurt at the time of the incident. CNA #1 stated that Registered Nurse #1 assisted the two CNA's in placing the resident back into the shower chair. She reported that Registered Nurse #1 examined the resident while she was sitting in the chair. She reported that she left the room to care for other residents after placing Resident #1 in the shower chair. CNA #2 was interviewed on 12/8/06, at 3:10 PM. She stated that she had asked CNA #1 to assist her in transferring Resident #1 out of bed for her shower. She reported that the resident's legs folded under her and they were unable to safely	F 272	licensed staff and assess appropriate interventions, treatment as needed, and update the resident care plan. The Director of Nursing or Designee will monitor and review, on a random basis, resident medical charts and care plans to ensure compliance. Discrepancies will be presented to the QA/QI committee for review.	

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F 272	Continued From page 4 place her on the shower chair. She confirmed that a popping or cracking sound was heard and the resident said "ouch, ouch, my leg." She reported that she thought the plastic part of the catheter was stepped on. She stated that they slowly lowered the resident to the floor and CNA #1 went to get the nurse. CNA #2 reported that the nurse helped the two CNA's place Resident #1 in the shower chair. She reported that Registered Nurse #1 checked the resident's leg while in the chair and did not examine the resident before moving her back into the shower chair. She stated that the resident was asked if she was okay and she responded that she guessed she was okay. CNA #2 stated that Registered Nurse #1 told her she could shower Resident #1. She reported that during the shower the resident did complain about sitting in the chair during the shower and wanted to go back to bed. The resident was reported to have been placed back into bed but complained of pain in her right leg when the CNA attempted to place an incontinence pad on her. She said she informed the nurse of the resident's pain. On 12/8/06 at 3:50 PM, Registered Nurse #1 was interviewed. He reported that he was at the nurse's station when CNA #1 told him that Resident #1 was lowered to the floor. He stated that the resident was on the floor with her knees bent. He reported that the resident complained of right leg pain but he did not examine her before moving her to the shower chair. The resident was lifted from the floor and placed into the shower chair. He stated that he assessed the resident while she was sitting in the chair but acknowledged that he could not assess for	F 272		

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F 272	Continued From page 5 external rotation or leg length discrepancy with the resident in a seated position. He stated that he saw no abnormality when he examined the resident in the chair. He confirmed that the resident was complaining of right leg pain but he did not believe the pain was deep enough to be caused by a fracture. Registered Nurse #1 reported that he did tell CNA #2 that she could shower Resident #1 since he did not believe the resident had a fracture. He reported that the CNA told him that the resident was still having pain after being placed back to bed. He examined the resident's right hip and leg again and found the right hip to be swollen and noted tenderness from the right hip to the knee. He contacted the resident's physician and an x-ray was ordered. The x-ray results indicated the resident had sustained a fracture of the right femur. Registered Nurse #1 reported that Resident #1 did complain of right let pain but he said she was not screaming that her leg hurt. He stated that he was not sure what word to use to describe how the resident reported her pain. He stated that he believed that the CNA's did not tell him of the popping or cracking sound heard by the CNA's until after the resident was showered. On 12/12/06, at approximately 1:10 PM, CNA #1 was interviewed and indicated the nurse had been told of the popping sound when first informed that the resident was on the floor. CNA #2 was also interviewed on 12/12/06 and also indicated that the nurse was informed of the popping or cracking sound before the resident was placed in the shower chair.	F 272		

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F 272	Continued From page 6 On 12/12/06 at 1:45 PM, an attempt was made to interview Resident #1 regarding the incident. She had returned to the facility on 12/10/06, after having surgery to repair her fractured right leg. She was alert but confused to place, time and recent events. Nursing staff reported that she was receiving Vicodin for pain and that the medication was most likely contributing to her confusion.	F 272		